Employment Development Department
State of California

Health and Human Services Agency
P.O. Box 826880 / MIC 94 / Sacramento, California 94280-0001 / (916) 464-2500

For Department Use Only

Account No. _____
Statistical Code _____
Effective Date _____
Classified By _____
Date _____
Employer Notified _____ (Date)
Send _____
Number of Employees _____

Application for Elective Coverage of Disability Insurance Only for Employees of a Public School Employer Under Section 710.4 or a Public Agency Employer Under Section 710.5 of the California Unemployment Insurance Code

IMPORTANT

This form is not an application for an account number under the compulsory provisions of the Unemployment Insurance Code. Do not complete this form unless you wish to apply for Disability Insurance coverage ONLY under Section 710.4 or 710.5 for your employees. Coverage under these sections of the Code does not make provision for Unemployment Insurance benefits.

NOTE: If your application is approved, the elective coverage agreement will be subject to all of the requirements and conditions outlined in form DE 1378P, "Information Concerning Elective Coverage Under Section 710.4 or 710.5 of the Unemployment Insurance Code." Please retain your copy of form DE 1378P for reference.

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Please Type of Print

1. Name of Employer _____ (Telephone)
2. Business Address _____ (Street and Number) (City) (County) (State) (ZIP Code)
3. Mailing Address _____ (Street and Number) (City) (County) (State) (ZIP Code)
4. Type of Public Employer - (Check one)
   - ☐ Public School - Section 710.4
   - ☐ Public Agency - Section 710.5
5. Law under which agency was established.
   (a) California General Laws
   Title of Act _____ Number _____ Year Enacted _____
   OR
   (b) California Codes
   Title of Code _____ Number _____ Part _____ Chapter _____
   Sections _____ to _____
6. Members of governing body of the employer.

Name	Title	Residence Address

7. This application covers employees of the following appropriate units:

	Show Name of Bargaining Unit or Describe Type of Services
☐ Bargaining Unit	
☐ Management	
☐ Confidential	
☐ Unrepresented	

8. Complete this schedule covering all elected officers and appointees who perform services for the agency names in Item 1. Exclude persons listed in Item 6.

   (a) Elected offices: (These persons are ineligible for coverage.)
   Title of Position

   (b) Person holding appointive positions: (These persons are eligible for coverage unless appointed to fill a vacant elected office.)

Title of Position	No. of Positions in this Category	By Whom Appointed	Number of Such Persons Desiring Coverage

   (c) Total number of employees to be covered (excluding elected officers and those appointed by the Governor).

9. Deductions should not be made from your employees' wages for the purpose of paying employee contributions required under the Code until your election is approved.

10. On what date do you wish elective coverage to commence? Keep in mind that the commencement date of an elective coverage agreement shall not be prior to the first day of the calendar quarter in which the application is filed, nor later than the first day of the following calendar quarter.

    ☐ First day of current quarter ☐ First day of next quarter

11. Attach a copy of the resolution in which the governing body described in Item 6 approved the filing of an application for elective coverage under Section 710.4 or 710.5 of the Unemployment Insurance Code.

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The governmental entity described in Item 1 hereby files its application under Section 710.4 or 710.5 of the Unemployment Insurance Code to become an employer subject to the Code. It is understood that upon approval of the election by the Director, the Public School/Public Agency Employer will be an employer subject to the Code for Disability Insurance purposes only to the same extent as other employers as of the date specified in the approval, and will remain a subject employer for at least two complete calendar years and thereafter, until this election is terminated as provided by the Code.

I declare that this application has been examined by me, and to the best of my knowledge and belief, it is true and correct and made in good faith under the provisions of the California Unemployment Insurance Code.

This declaration must be signed by one or more persons shown under Item 6.

(Signed) _____ Date _____

(Signed) _____ Date _____

(Signed) _____ Date _____